DOCUMENT RESUME

ED 380 713 CG 025 913

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TITLE National Healthcare in the United States: What Counselors Should Know.
PUB DATE [94]
NOTE 76p.; Paper presented at the Regional Meeting of the Association for Counselor Education and Supervision (1994).
PUB TYPE Information Analyses (070) -- Speeches/Conference Papers (150)

EDRS PRICE MF01/PC04 Plus Postage.
DESCRIPTORS Counseling Services; *Counselors; *Health Care Costs; *Health Insurance; *Health Needs; *Health Programs; Health Services; Insurance; National Programs; Public Policy
IDENTIFIERS *National Health; National Health Insurance; *United States

ABSTRACT

Few articles in the professional counseling literature address the healthcare crisis. This paper examines the current state of the United States healthcare affairs. Topics discussed include the problems in healthcare, including an inspection of the uninsured, the underinsured, rising healthcare costs, and the growing inequality in the healthcare system. Since many countries with national healthcare systems view healthcare as a right, examples of national healthcare systems world wide are offered, with overviews of systems in Germany, Great Britain, Sweden, Canada, Japan, and elsewhere. Next, the various attempts to change the U.S. system, including information on state plans, previous proposals for national healthcare reform, and some of the current plans for reform, such as national health insurance, single payer plans, a national health service, managed competition, various health acts, and other recommendations. The variety of possibilities have created many opponents and proponents of national healthcare plans are examined. These persons' views are evaluated along with an outline of actions deemed necessary in healthcare reform. Counselors must become involved in the debate by responding to social and public policy in a more organized fashion, by lobbying for progressive healthcare reforms, and by working in conjunction with other mental health providers. (Contains over 300 references.) (RJM)

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NATIONAL HEALTHCARE IN THE UNITED STATES: WHAT COUNSELORS SHOULD KNOW

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Abstract

This article provides an overview of the healthcare crisis in the United States; discusses the concept of healthcare as a right; examines existing systems of national healthcare; state plans to deal with the problem; a brief history of U. S. national healthcare reform efforts; classification of types of national healthcare reforms; current reform bills in Congress; sources of opposition to and support of reforms; and, a call for support of reforms and counselor involvement in the process.

NATIONAL HEALTHCARE IN THE UNITED STATES: WHAT COUNSELORS SHOULD KNOW

Introduction

Healthcare in the United States (U.S.) is clearly in crisis ("Access to Care", 1991; American Nurses Association [ANA], 1991; Barer & Evens, 1992; Bayer, Callahan, Caplan & Jennings, 1988; Bingaman, Frank, & Billy, 1993; Botelho, 1991; Bronow, Beltran, Cohen, Elliott, Goldman, & Spotnitz, 1991; Butler, 1992; Butler et al., 1992a, 1992b; Clark, Hager, Hutchinson & Springen, 1988; Clinton, 1993; Committee on Labor Resources, 1993; "Crisis in Health Insurance", 1990; "Crisis in Health Insurance, Pt. 2", 1990; Frank, 1989; Goffman, 1989; Grumbach, 1992: Haislmaier, 1989; Hiatt, 1987/89; Hilts, 1991; Himmelstein, Woolhandler, & The Writing Committee of the Working Group on Program Design, 1989; Intriligator, 1993; Kaplan, Sallis & Patterson (1993); Kennedy, 1990, 1991; Matthiessen, 1990; Navarro, 1987; Neff, 1990a; Oil, Chemical & Atomic Workers, 1989; Rosenau, 1993a; Schell, 1989; Vanden Bos, 1993; Wing, 1988; Woolhandler & Himmelstein, 1989a, 1989b).

Counselors, regardless of their specialty or work setting, have come to know that healthcare in the U.S. has serious problems. We have seen too many clients (or their family members) whose health have deteriorated because they have been unable to pay to see health care providers and haven't had insurance to cover the services. We have also seen many clients who had to discontinue counseling for the same reasons. Many of us have also seen family and/or friends in

these situations. Yet, little has been written in the professional counseling literature concerning the healthcare crisis. Changing Contexts for Counselor Preparation in the 1990's (Hackney, 1990), published by the Association for Counselor Education and Supervision, does not mentioned the healthcare crisis. This omission occurs even with one of the chapters dealing with health (Robinson & Roth, 1990).

This paper examines the current state of U.S. healthcare affairs. Sections of the paper include: (1) the breadth and scope of the crisis in healthcare; (2) current national healthcare systems; (3) state-government level efforts to "fix" the healthcare crisis; (4) an overview of current national proposals (including President Clinton's plan); (5) support and opposition of national healthcare reforms; and, (6) recommendations regarding what counselors should be doing to impact reform.

The Crisis In Healthcare

U. S. President Clinton maintains that "this health care system of ours is badly broken and it is time to fix it" (Clinton, 1993, p.2). In this section the scope of the problems in the U.S. healthcare system is addressed. This includes: 1) the uninsured, 2) the underinsured, 3) rising healthcare costs, and 4) growing inequality in the healthcare system.

The Uninsured

Uninsured persons are those who have no coverage from private or public sources. Estimates of the number of the uninsured vary

from 31 to 37 million ("Crisis in Health Insurance", 1990; Mahrenholy, 1991); 32 million (Belcher & Palley, 1991), 33 to 37 million (Montauk, 1991), 35 million (Aaron, 1992; Aaron & Schultze, 1992; Dougherty, 1992; Grace, 1990; Kerry & Hofschire, 1993 ; Smith, 1988), 36 million (Bingaman et al., 1993; Frank, 1993), 37 million (Blendon, 1989; Levey & Hill, 1987; Clark et al, 1988; "Comparison of National Health", 1992; Davis, 1989a; Goodman, 1990a; Hiatt, 1987/89; Kennedy, 1990; Lindroff, 1989; Nixon & Ighagni, 1993), 37 to 40 million (Arndt, 1989a), "as many as 39 million" (Hanson, 1993, p.760), approximately 42 million (1 in 6 people in the U. S.) (Atkins, Decker & Sokolov, 1990). Gordan cites the number of Americans without a "regular source of healthcare" at "almost 50 million" (p.376), while Weil (1991) contends there are "63 million people uninsured sometime during the year" (p.533).

Woolhandler and Himmelstein (1989b) report that the number of people without private insurance increased 47% between the years of 1980 to 1985 and state the number is rising. Hiatt (1987/89) states that the number of uninsured grew 50% between 1977 and 1989. Aaron and Schultze (1992) calculate the rise in the number of uninsured "from 27 million to 35 million," (p. 3), or an increase of 25.9 percent. Blendon (1989) cites a 25% increase in the overall number of uninsured in the U. S.

Uninsured children and youth present a particular concern. The number of children without insurance is estimated to be one-third of the total number of the uninsured (Dougherty, 1992). Rosenbaum stresses that "good health is essential to children's development, and every child needs health care" (1992, p. 275). One source sets

the percentage of youngsters under the age of 18 without health insurance at 17.8 ("Number of Uninsured Children", 1991, p. 6). The aforementioned study also reports that during the 1977 - 87 period the "percentage of children without health insurance increased 40%" (p. 6). Among adolescents, the number of uninsured is cited as 4.6 million (Eden, 1989), and as "1 in 7 youths ages 10 to 18" (Associated Press, 1991, p. A2). Both of these figures roughly equal 15 percent of all adolescents. Eden (1989) states that between 1979 and 1986 the "percentage of adolescents without insurance increased by 25%" (p. 3392). Dentzer (1990) sums up of the situation by proclaiming that "the poor care afforded many American children is a scandal, especially since providing basic care is extremely cost effective" (p. 27).

The Underinsured

Underinsured persons include: those who have such high deductibles or co-payments that they cannot afford to go to a physician; those who cannot purchase the required medications after they are prescribed; and, those who are "one serious illness away from losing all their savings" (Clinton, 1993, p. 4). According to Kaplan, et al. (1993) "medical bills are the number one reason for personal bankruptcy in the United States" (p.76). The number of underinsured is estimated to be from 30 million (Grace, 1990), 33 to 37 million (Montauk, 1991), 50 million (Belcher & Palley, 1991; Mahrenholy, 1991; Nixon & Ighagni, 1993), 60 million (Kennedy, 1990), to 70 million (Hanson, 1993).

Santiago (1992) puts the combined number of un- and under-insured at 50 million. The ANA (1991) places the combined figure at "more than 60 million" (p. 7). Whatever the accurate numbers are, it is clear that uninsured and underinsured people constitute a serious problem for the healthcare system and the country. When people are unable to pay for or do not have any (or inadequate) insurance coverage, providers charge others more to recoup these costs. This can be in the form of higher fees, higher taxes or higher premiums.

Spiraling Health Care Costs

Relman (1991) expressed it well when he said "what we see now is a market-oriented health care system spinning out of control" (p. 856). This view is also supported by Arron who contends that costs are "high and soaring" (1992, p. 23) and Kaplan, et al. (1993) who warn that "costs are raging out of control" (p. 76). The U. S. spends more per capita and a higher percentage of its Gross National Product (GNP) than any other country in the world (Aaron, 1991; Rhodes, 1992; Rosenau, 1993b; Sager, 1988). Per Capita expenditures are $2,051 (Aaron, 1991) and GNP is 14% (Congressional Budget Office, 1993). In terms of Gross Domestic Product (GDP) the U. S. spent 13.4% in 1991, compared to the next highest country, Canada, who spent 10.0% in the same year (Passell, 1993). Arron (1991) states "health care absorbs 15 percent of net domestic product" (p. 23). In spite of this high spending we rank 12th in Life Expectancy (Missouri Citizen Action, 1990b), 22nd in Infant Mortality (Missouri Citizen Action, 1990a) and 20th in Child Mortality (Missouri Citizen Action, 1990a). Some critics have stated that the U.S. receives

much less for its money than other countries with National Health Insurance or a National Health Service who spends as little as half as much (National Health Care Campaign, 1988; Shannon, 1989). Clinton (1993) contends that U.S. healthcare is "the costliest and most wasteful system on the face of the Earth" (p. 5).

The cost for insurance is rising at a rate of 20% per year (Baker, 1991). Overall spending in healthcare has been in double-digits for some time now - with the 1990 increase at 10.5 % more than 1989, and this acceleration over two-times that of the GNP ("Health Care Spending", 1992). "Crisis in Health Insurance" (1990) proports that often, even when employers offer insurance coverage, workers cannot afford the premiums, leaving them uninsured. The current Chair of the Clinton administration's Council of Economic Advisors predicts that if no healthcare reform is passed 18% of the US GDP will be spent on healthcare by the year 2000 (Tyson, 1993).

A major burden of the American healthcare system is the enormous amount of administrative costs. McAuliffe (1987) asserts "as much as 20% of some U. S. medical bills" is consumed by administrative costs (p. 29). Relman (1991) reports estimates of administrative costs "between 19 and 24 percent of total spending on health care, far more than in any other country" (p.856). In 1988 Huey set the costs at "22¢ on the dollar" (p. 1484). An example of why these administrative costs are high was recently revealed with a report of a health insurance company that paid close to $1.4 million in bonuses to its executives just months before it began laying off workers at its home office (Margolis, 1992).

Increasing Inequity in Healthcare Delivery

Research has shown that there is a growing gap between those with access to quality care and those without health insurance or the ability to pay (Angier, 1990; Dougherty, 1992; Hiatt, 1987/89; Melnick, Mann & Golan, 1989; National Health Care Campaign, 1988; Weissman & Epstein, 1989) and that "for virtually all the major causes of death there are significant differences between high-income and low-income people" (Kaplan, et al., 1993, p. 432). These have dire consequences. One study found that "sick newborns who lack health insurance [receive] less medical care in hospitals than newborns covered under private policies or Medicaid" (Coleman, 1991, p. 6A). Nine to Five (1990) reports that uninsured babies are 30% more likely to die or have serious medical problems than babies with insurance.

Harrington (1988), in discussing the shortcomings of the federal health insurance program for the poor (Medicaid), states that "only 64 percent (21 million) of the 33 million persons living in poverty were covered in 1984 [due to] eligibility limitations imposed by various state programs" (p.214). Tallon (1989) wrote that in 1988 "11 million persons with incomes below the federal poverty level were without health insurance," and "over 50% of the poor did not qualify for Medicaid" (p. 1044). Thorpe and Siegel (1989) report that the number of persons below the federal poverty line not covered by Medicaid is at "more than 10.9 million" (p. 2114). The number of the poor covered by Medicaid is said to be only 38% of all the poor ("Crisis in Health Insurance", 1990). The federal poverty line is much below what many Americans and most counselors would

consider a decent standard of living. Lindorff (1989) cites a 1989 U. S. government report that concludes that medical care is "probably out of reach for more than half of all Americans who are uninsured, underinsured or dependent on Medicaid" (p.69). A disturbing trend reported by Headen (1990) is that "black and Hispanic workers" make up a large percentage of the "low-coverage and high-risk" group (p.31).

More generally, many authors have stated that the U. S. system is: unfair (Hackman & Howard, 1989; Smith, 1988); lacks access for many citizens (Huey, 1988; Iglehart, 1989; Popko, 1992); and, that persons are "forced to do without...adequate care" (Henry, 1990, p.33). Kennedy (1990) reveals that every year one million people in the U. S. "are refused healthcare because they cannot pay" and that an additional 14 million "do not even seek the care they need because they know they cannot afford it" (p. 30). Aaron (1992) points out that "for people in poor neighborhoods, services are unavailable, hard to reach, or available only from impersonal and expensive hospital emergency rooms" (p. 23).One report cites that many insurance companies are black-listing certain occupational groups that they deem as too high-risk, thereby limiting the amount of claims they have to pay out (Freudenheim, 1990a). Sidel (1987) argues that there is "a troubling gap in health and health services between the rich and poor" (p. 24). Terris (1990) puts forward the idea that the U.S. system is "essentially regressive, in that it hits lower-income groups the hardest" (p. 28).

Another concern is that for-profit hospitals are mainly "located in affluent suburbs, where the pressure to provide charity care was

reduced" (Ginzberg, 1988, p. 757) and skim off patients who can pay or are insured from public and inner city hospitals. Navarro (1987) asserts that the system is, in fact, a "non-system" that is "inhuman" (p. 148). "'System' is a misnomer. Healthcare for Americans is shaped by a jerry-built aggregate of institutions" professes Hiatt (1987/89, p. 69). Winkenwerder and Ball (1988) state that "the values reflected in the health care system are primarily a function of those who hold power" (p. 319).

It should be clear by this time that the U. S. healthcare system is in need of major reform (Rosenau, 1993b). Nixon and Ighagni (1993) proclaim "it is no longer disputed that the health care system in the United States needs a major overhaul" (p.813). McGroth (1993) sums it nicely in saying, "only someone who is very healthy or very wealthy could be unaware of the need for complete reform of our nation's health-care system" (p.19, C-1). Approval in the U. S. for "a plan financed entirely by government" Blendon and Donelan report, is "at the highest point since World War II" (approximately 64%) (1990, p. 208) They further report that 72 to 73% "favor some form of a national health care program" (p. 208). Another study found that 73% of those polled believe that the U. S. "should have a national health insurance plan under which the government would provide health insurance for everyone" ("Consumers Give Thumbs-up Sign", 1990, p. 20). Blendon (1989) reports a "striking 89 percent of Americans see the U. S. health-care system as requiring fundamental change in its direction and structure" (p. 3). Colatosi (1990) puts this figure at 90%. Feldman (1990) asserts "there has been an outcry for a national health insurance program" (p. 3).

The "debate about national health care and universal access has become more intense than at any time since Truman's presidency" (Editors, 1991). Morris soberly claims that "the coming debate about the future of our health care system may be the most important one of our lifetime" (p. 7A). Senator Kennedy calls this "the most significant domestic policy debate since Medicare was enacted almost 30 years ago" (cited in Committee on Labor Resources, 1993, p.1).

One writer puts it well when he proclaims that "giving only some people access" to basic medical care, "while others are denied for no better reason than lack of money, it stinks of privilege. And when anything stinks, it is a summons to change" (Wilson, 1990, p. 23).

Healthcare As A Human Right

Countries that have national healthcare systems tend to view healthcare as a right. Botelho (1991) points out that "all other western democracies implicitly or explicitly" hold this position (p. 863). In 1948 the U. N. passed the Universal Declaration of Human Rights which includes the right to healthcare as a basic human right (Dougherty, 1988; Schwelb, 1964). This right is recognized in some form by all industrialized countries except South Africa and the U. S. (Dougherty, 1988; Roemer, 1991; Sakala, 1990).

Many observers in the U. S. also support the view of healthcare as a human right (Belcher & Palley, 1991; Botelho, 1991; Boyle, 1985; ; Halamandaris, 1990; Jacob, 1992; Kelly, 1985; Kuttner, 1987; Montauk, 1991; Navarro, 1987; Oil, Chemical & Atomic Workers, 1989; Popko, 1992; Roemer, 1991; Rosenbaum, 1992;). Navarro

(1987) advocates for the U. S. "to join the rest of the civilized nations and recognize that health is a human right" (p. 151). Additionally, many groups also support the right to healthcare, such as the American Association for Retired Persons (Henrey, 1990); Catholic Bishops (Miller, 1985); the Gray Panthers ("Gray Panther Principles", 1990); and, organized labor (Labor/Higher Education Council, 1990).

In the U. S., healthcare is not a legal right, although the U. S. is a signatory to the UN Universal Declaration of Human Rights (Dougherty, 1988). In this "we stand alone among the industrialized nations of the world" (Berwick & Hiatt, 1989, p. 541). In litigation, courts have not upheld any legal right to medical care, as Curran (1989) explains. The only way to guarantee this, he goes on to say, would be to "amend the Constitution formally to establish such a new civil right" (p.789).

National Healthcare Systems World Wide

Much has been written about other countries' systems of national healthcare. Aaron (1991) states that "interest in foreign health systems is increasing in the United States" (p.78). The U. S. is the only industrialized democracy in the world without some form of National Health Care (Davis, 1975; Dougherty, 1992; Navarro, 1984; Sager, 1988; Sakala, 1990;) and the only developed country except South Africa without such a system (Hiatt 1987/89; Flemming, 1989; Woolhandler & Himmelstein, 1989b).

Feldman (1990) observes that advocates for reform "have pointed to many countries -- Canada, Great Britain, West Germany and Japan

among them as models of healthcare efficiency" (p. 3). National Health Care Campaign (1988) puts forth that countries with national healthcare systems keep "costs down and efficiency up -- through: (1) careful planning, (2) a focus on prevention, (3) single source payment system, and (4) streamlined, centralized administration" (p. 18). Concerning the cost of healthcare, Iglehart reports "most Western countries have concluded that the financial consequences of illness should be borne by societies, not individuals" (1989, p. 1767). Before we turn our attention to specific countries, let us first explore ways of thinking about healthcare systems.

National healthcare systems can be roughly categorized as national health insurance, national health services, or a mixture of the two. Additionally, funding can be totally public, totally private, or a mixture. Most systems tend to be mixtures.

Roemer (1993) has developed a classification system that places countries "going from the least market intervention to the most" and maintains that the four main types of healthcare systems are "entrepreneurial, welfare oriented, comprehensive, and socialist" (p. 695-6). Examples of these classifications are: entrepreneurial- the United States (the only country in this category); welfare oriented - Canada, Japan, Australia and many Western European countries; comprehensive - Great Britain, Costa Rica, Sri Lanka and the Scandinavian countries; and, socialist - the former U. S. S. R. (Roemer, 1993).

We now turn to an examination of selected countries ' systems.

Germany

The first system of national healthcare came into existence in 1883 when the German government instituted the first national compulsory health insurance law (Bodenheimer & Grumbach, 1992). Since the unification of the former German Democratic Republic ("East Germany") with the Federal Republic of Germany ("West Germany"), the system has changed, but retains the key elements of the former West Germany, while trying to incorporate the positive elements of the former East Germany's national health service (Page, 1990).

The West German system centered around what are called "sickness funds" (McIlrath 1990). These funds cover approximately 90% of the population and are financed through payroll taxes (McIlrath 1990). There are approximately 1,200 sickness funds (Wysong & Abel, 1990). Many of these funds are administered jointly by the employer and the workers' labor union officials (Colastosi, 1990). Funding for the healthcare system is from: private and public employers- 42%, employees- 37%, federal, state and local governments- 21% (Wysong & Abel, 1990).

Economic comparisons for the unified Germany are unavailable at this point. West Germany, in 1987, spent only 72% as much of its G. D. P. for healthcare as the U. S. (Aaron, 1991). West Germany ranked 14th for infant mortality and 17th for child mortality (Missouri Citizen Action, 1990a). Public opinion regarding the German system is favorable, overall (Hagland, 1991).

Great Britain

The British system is an example of a national health service where medical care is seen as a right of citizenship (Harrington, 1990; Lindquist; 1984). It was established by the Labor government under the leadership of Health Minister Aneyarn Beven on July 5, 1948 and "was the first country in the world to offer free medical care to the whole population" (Abel-Smith, 1990). Bevan, in discussing healthcare, wrote, "preventable pain is a blot on any society" (1964, p. 100). Previous to the national health service, the British government had developed a national health insurance system in 1911 (Glaser, 1984).

The British National Health Service (N.H.S.) is "overwhelmingly financed and organised by the central government" (Allen, 1984, p. 197). Hospitals and the doctors who work there are employed by the government ("Comparison of National Health"; 1992); although, the Conservative government has endeavored to "encourage competition, entrepreneurship, and elements of privatization" (Vall-Spinosa, 1991, p. 1567). These "reform" measures are opposed by every major physician organization and medical group (Foot, 1991), with the British Medical Association "waging a major public relations war against" the Conservative's proposals (Lundberg, 1989, p. 3107). Harper (1989) observes that "it's difficult to find anyone in health care who backs the government's proposals" (p. 88). Even with the Conservative government of the past several years, only a few changes have been made to the system (Wing, 1988).

A British person signs up on a General Practitioner's (G.P.) "list" and the G.P provides services (and is paid at a pre-established governmental rate), as well as serving as a gatekeeper for access to

specialists (called "consultants"), (Aaron & Schwartz, 1984; Allen, 1984; "Comparison of National Health", 1992; McAuliffe, 1987; Vall-Spinosa, 1991). Health promotion and prevention of illness are key factors in the British system (Allen, 1984). The N.H.S. covers hospital stays (except for elective surgery), services provided by a physician, prevention services, in-home and nursing home care, prescription drugs, vision care, psychiatric care, and limited dental services ("Comparison of National Health", 1992). Medical services in Great Britain "are distributed throughout the country," and " everybody, independent of geography, income, or family status, has access to medical care, and...even prolonged illness bankrupts nobody" (Hiatt, 1987/89, p. xix).

All of these services are provided to the citizenry, yet Great Britain spent less than half as much in 1991 as the U. S. as measured by percentage of G. N. P. for health expenditures (Passell, 1993) and with better Infant and Child Mortality rates than the U. S. ("Comparison of National Health", 1992; Missouri Citizen Action, 1990c) and a longer average life-span ("Comparison of National Health", 1992). The British are also more satisfied with their healthcare than are U. S. citizens (Blendon, 1989).

Sweden

The Swedish system is also a national health service and is considered the most comprehensive system in the world ("Comparison of National Health", 1992; "National Health", 1988). Adelman (1989) states the system "exists within a comprehensive social welfare system in a modern industrialized nation with a

highly educated populace" (p. 29). Sweden's health care system is almost totally financed and operated by the government ("Comparison of National Health", 1992; "National Health", 1988). The Swedish Institute (1986) reported that "the fundamental principle of [Swedish] health care policy is that all inhabitants should have the same opportunity to stay in good health and be equally entitled to healthcare, regardless of where they live in Sweden, [or] what economic recourses they have" (p. 3).

Coverage in Sweden includes: stays in the "hospital (tests, lab work, non-elective surgery), physician services, preventive care, home care and nursing home care, prescription drugs, dental care, eye care, paramedical services, and psychiatric care" ("Comparison of National Health", 1992, p. 203). Additionally, citizens receive 90% of their wages when they're sick, or when a parent is forced to stay home with a sick child (Pedersen, 1990).

The Swedes managed to provide this level of care and in 1991 spent only 64% of what the U. S. spent, as measured by percentage of G. D. P. (Passel, 1993). Sweden ranked third in Infant Mortality and of Child Mortality in the world (Missouri Citizen Action, 1990a) and has a longer average life-span than that of the U. S. ("Comparison of National Health", 1992).

Canada

The Canadian system has undoubtedly received the most attention in the U.S. healthcare debate (Barer & Evens, 1992; Evans et. al., 1989). Their system is a national health insurance scheme that was developed in a series of governmental acts, the first a hospital

services plan initiated by the Province (similar to a U.S. State) of Saskatchewan in 1947, with the other provinces following, and leading to a national hospital plan in 1958 (Taylor, 1990). Saskatchewan took the lead, again, in 1962 with passage of a medical care insurance program; and by 1968 a national health care insurance program was passed at the federal level (Taylor, 1990). In 1984 the Canada Health Act was passed that unified the previous plans and set minimum standards of care and provisions for provincial (and territorial) administration (Taylor, 1990). The Federal Ministry of Health establishes these standards and has jurisdiction over provincial annual plans ("Comparison of National Health", 1992). The Act, which passed unanimously, states in its preamble that "the primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada..." (Evans, 1989, p.79).

There are five basic principles of the Canadian healthcare system: 1) Universality (for all Canadians), 2) Portability (coverage follows the person from province to province [or territory]), 3) Comprehensiveness (all services- except for private hospital rooms and a few other things), 4) Accessibility (of facilities), and 5) Public Administration (Huey, 1988).

Benefits of the Canadian system are much the same as Sweden's, with the exception that vision care is not covered and dental care is limited ("Comparison of National Health", 1992). Part of the underlying belief is that everyone should have "equal access to medical care, regardless of ability to pay" (Iglehart, 1990, p. 562).

Trimbell (1992) insists that the Canadian system "places a higher value on social equity than the U. S. does" (p. 367).

An element of Canada's healthcare that critics like to point out is that of rationing care (e. g., Arnett, 1993); although Brewer (1991) contends that much of the criticism of the Canadian system is false and/or misleading. Kosterlitz (1989a) indicates that rationing was done to provide "medical care according to need rather than by income or work status" (p. 1793).

One component of the Canadian system that many reformers in the U. S. look to is its low administrative costs. Some authorities place the figure at approximately 3 percent (Freudenheim, 1989; Hiatt, 1987/89), while Huey (1988) cited approximately 2.5% (compared to 22% for the U. S.). Evans et. al. (1989) state "for the Canadian physician, differences in the costs of insurance administration show up as a lower overhead for practice" (p. 573). The fact that the system is a single-payer one is to what a Canadian hospital official attributes the country's lower healthcare costs (Geisel, 1991a). Linton puts forth that "the demonstration that a single-payer public system is in fact more efficient than private insurance and competition has raised difficult questions in American minds" (1990, p.198).

Additionally, there are many other interesting features of the Canadian system. Over fifty percent of physicians there are family practitioners and general surgeons (Hagland, 1991b) and they have "little or no external interference with patterns of medical practice" (Relman, 1989, p.320). There are more physician services in Canada than the U.S., while physicians in the U. S. charge more for

their services and make more money (Fuchs & Hahn, 1990). Physicians, overall, are positive about the state of Canadian healthcare as evidenced by a 1987 poll that revealed "60% were satisfied" practicing medicine in Canada, "while 24% were dissatisfied" (Meyer, 1989b, p. 24). Linton (1990), claims "physicians in Canada still enjoy much more professional autonomy that their U. S. colleagues" (p. 198). Additionally, Canadians are free to choose their own physicians (Taylor, 1990).

Canada spent 74.6% as much of its G. D. P. as the U. S. in 1991 for healthcare, yet managed to provide universal coverage with good quality of care (Passell, 1993). Their system, according to Linton (1990) is seen as "one of the best...in the developed world" (p. 197). They ranked 11th in Infant Mortality and 6th in Child Mortality in the world (Missouri Citizen Action, 1990a) and have a longer average life-span than that of the U. S. ("Comparison of National Health", 1992). Canadians, for the most part, are satisfied with their healthcare system and much prefer it to the U. S. system (Blendon, 1989). A recent study reports "more than 85% of the public, in spite of waiting times, are very satisfied" with the Canadian system (Geisel, 1991a, p. 26). Part of their system involves rationing non-life threatening work, but even with this, "nobody in Canada argues against the national health system, no matter what political party they are from" (Butler et. al., 1992a, p. 42). Hatcher, Hatcher and Hatcher (1984) assert "Canada retains a single service for rich and poor alike-not a two-class system. It has proven to be of good quality, yet inexpensive, free to all, yet not abused" (p. 109). McAuliffe (1987) goes so far as to state that Canada "is an even

better model [for U.S. reform efforts to look at] because their situation ran parallel to ours in several respects" (p. 29).

Japan

Japan first passed its Health Insurance Law in 1922 to cover workers in manufacturing and mining industries of the country; although, enforcement was delayed until 1927 (Hashimota, 1984). This was followed in 1938 by the National Health Insurance Law that covered workers in farm, forestry and fishing industries, and the government has revised this several times through 1961 when universal coverage was obtained (Hashimota, 1984).

The Japanese healthcare system is "based on three essential objectives: ready access, high quality and reasonable costs" (Iglehart, 1988, p. 807). Article 25 of their constitution "declares that the promotion and improvement of public health, together with social security and social welfare, are the responsibilities of the nation" (Hashimota, 1984, p. 337). Coverage is extend to all workers and their families through federally mandated coverage and all others have care provided by a national health insurance program (Anderson, 1991; "Comparison of National Health", 1992). Benefits for Japanese citizens are basically the same as for the Swedes, except that dental care is limited, and vision, psychiatric care and paramedical treatment are not covered at all ("Comparison of National Health", 1992).

Japan provides these services while spending only 6.6% of its 1991 G. D. P., or only 49% as much as the U. S. in the same time period (Passell, 1993). Japan ranks 4th in infant mortality and 5th in

child mortality (Missouri Citizen Action, 1990a) and an average life expectancy that is two years longer than the U. S. ("Comparison of National Health", 1992). Iglehart asserts that the Japanese people are "the healthiest in the world" (1988, p. 810).

Other Countries

Several other countries have some form of national healthcare systems. Those with a national health insurance system include: Austria (Zimet, 1989); Belgium (Nys & Quaethoven, 1984; Roemer, 1991); France (Glaser, 1984; Lacronique, 1984; Meyer, 1989c); The Netherlands (Roemer, 1991) {interestingly, The Netherlands outlaws managed care plans (Anderson, 1991)}; and, Thailand (Meyer, 1990). While Australia (Dewdney, 1984; Johnsson, 1991); Costa Rica (Roemer, 1993); Denmark (Sondergaard & Kransnik, 1984); Finland (Borgenhammer, 1984); Hungary (Frommer, 1993; Roemer, 1993); Iceland (Borgenhammer, 1984); Italy (Cohen, 1990); Malta (Agius, 1989); New Zealand (Brookes, 1989; Mackay, 1984); Nicaragua (Lawton, 1988); Norway (Borgenhammer, 1984); Poland (Roemer, 1993); and, Sri Lanka (Roemer, 1993), all have some form of national health service.

Attempts to Change the U.S. System

State Plans To Deal With The Healthcare Crisis

With the absence of a national healthcare system, many states have grappled with the problems in healthcare over the past few years. Shannon (1988) asserted "state health programs are perceived

by many as precursors to a national program" (p. 14). This position is also supported by Weil (1991).

The first state to act was Hawaii, which in 1974 passed a law that mandated that employers provide health insurance (Eno & Haugh, 1988). More recently the Hawaiian government passed further legislation that enacted a health insurance program for those who are not working to complement the above-mentioned employer mandate (Beauchamp & Rouse, 1990). Massachusetts passed a universal health care bill in 1988 (Roemer, 1991; Somerville, 1989a), but implementation has been delayed until 1994 (McGhee, 1990).

> Oregon's health plan, which has been controversial because it rations care: extends Medicaid coverage for a prioritized list of health services to all Oregonians with incomes below the federal poverty level [Creates a] high-risk pool to provide coverage to citizens unable to obtain insurance because of preexisting conditions.[And] mandated employers to provide health insurance coverage to all permanent employees (defined as working 17.5 hours [or more] per week) and their dependents, or to pay into an insurance pool fund (Southard, 1992, p. 471).

Connecticut has passed a plan to assist uninsured citizens (Schwartz, 1990b) as has Minnesota, (Jacott, 1993; Stych, 1992), New York (Somerville, 1989a), and Wisconsin (Somerville, 1989a).

Most other states have had some kind of plan or proposal either formally introduced into its legislature, or have considered doing so (Belcher & Palley, 1991; Cavanaugh & St. John, 1991; Eno & Haugh, 1988; "Health Care For All", 1988; Lande, 1989; Missouri Citizen

Action, 1990b; Morris, 1993; "N. Y. Report ", 1990; Pennsylvania Correspondent, 1989; Strasser, 1990). Plans to cover the uninsured were defeated in popular votes in California (Somerville, 1989a) and Missouri (Somerville, 1989a). There is much variation in state systems currently (Grogan, 1993).

In 1990 Florida, Illinois, Kansas, Kentucky, Missouri, Rhode Island, Virginia and Washington passed laws to encourage insurance coverage (Freudenheim, 1990b) and in 1991 California, Colorado, Delaware, Florida, Iowa, Kansas, Nebraska, New Mexico, North Carolina, Oregon, Rhode Island, South Carolina, Vermont, West Virginia and Wisconsin all "moved to make insurance more affordable for small employers" (Hanson, 1993, p. 764).

Now, we will turn to examining national plans to deal with healthcare. Sakala (1990) framed the issue well when he wrote, "the major question, then, is, can the U. S. rise above the plethora of state and local solutions to guarantee access and equity for all citizens" (p. 745).

Previous Proposals For National Healthcare Reform

There have been many proposals for national healthcare in the U. S. The history of reform efforts extend back at least 82 years when Theodore Roosevelt proposed a national health insurance act during his 1912 presidential campaigning (Feder, Holahan & Marmor, 1980; Marmor & Christianson, 1982; Sakala, 1990).

Proposals for a national health insurance plan received some attention during the formation of the New Deal (Harrington, 1986), but it "was excluded from the Social Security Act, following

protests from medical, insurance, and other interests" (Sakala, 1990, p. 710). President Truman first endorsed universal, comprehensive health coverage in 1945 (Poen, 1979), which was defeated in congress ("Evolution of Federal Health", 1987). Truman's plan would have covered all Americans, and he supported other health reforms as well (Califano, 1986). Truman (1956) wrote that among his "bitter disappointments as President" the one that bothered him the "most, in a personal way" was "the failure to defeat organized opposition" to national health insurance (p. 23).

Since the first reform plans where introduced, there have been many groups that worked to defeat them (Bevan, 1982). Belcher and Palley (1991) report this has been "in large part because of effective lobbying against national health insurance by the American Medical Association (AMA) and its traditional coalition allies such as the National Association of Manufacturers and the American Chamber of Commerce" (p. 103). They go on to state that the AMA's role in defeating Truman's plan in 1948 "was significant" (p. 106). Grumbach (1992) points out that the AMA "has been instrumental in blocking enactment of national health care in the U.S." (p. 350). Weil (1990), in attempting to explain the lack of support for national health insurance, professes it is because the concept is "alien to our values of pluralism, individual responsibility and a desire to solve problems at the local level" (p. 32); although, one could argue that he misunderstands the concept and how citizens view social values.

Current Plans for Reforms

Types of Plans

Sorting through the maze of healthcare reform proposals can be an overwhelming and tedious job. The terms used are often alien to counselors. A basic understanding of medicine, medical economics, economics, social and public policy, tax structures, social welfare, and politics is necessary for understanding many of the proposals.

Some attempts have been made to suggest schemes to classify types of plans. Harrington (1990) categorizes the current proposals for changes in our healthcare system as: "1. incremental expansion of the existing public programs... 2. mandatory requirements on employers to offer private health insurance; and 3. a comprehensive national health plan similar to the one in Canada" (p. 223). She goes on to advocate a Canadian-style system. Butler et. al.(1992b) overview possible solutions include: 1) "maintaining the status quo", 2) "development of a government-ran service, such as the British National Health Service or our own Veteran's Administration", 3) "a mandated universal health insurance program", or, 4) "tax credits to modify the way the current system works" (p. 38).

There is general agreement that whatever type of plan is adopted needs to provide universal coverage (Aaron, 1992). The AMA "no longer opposes efforts to include more Americans in a nationally mandated employer based" plan, according to Belcher and Palley (1991), "because it realizes that such a system would increase demand and provide a new source of payment to physicians from many patients" (p. 109).

1. National Health Insurance

The goals of national health insurance (NHI) should include: "(1) ensuring that all persons have access to medical care, (2) eliminating the financial hardship of medical bills, and, (3) limiting the rise of health care costs" (Davis, 1975, p. 2). Koshland puts forth that a "good national health insurance program would produce more equitable health coverage" (1990, p.9).

2. Single Payer

In a single-payer system there is only one entity that pays for health care, usually the government. Morris (1993) believes that this type of system is "easy to understand" (p. 7A). He goes on to report that a recent Harris poll revealed that "70 percent of Americans favor a single-payer approach that covers everyone equally." (p. 7A).

Colatosi (1990) believes that "much of the trouble [with the U. S. healthcare system] stems from the fact that health care is for profit" (p. 8), and goes on to suggest that we need a system "that eliminates the private insurance industry" (p. 9). A single-payer system would do just that. It would also control costs (Barer & Evens, 1992).

The Physicians for a National Health Program drafted a model plan based on the Canadian experience (Harrington, 1988), as did Himmelstein, Woolhandler, & The Writing Committee of the Working Group on Program Design (1989). A single-payer plan modeled after the Canadian system has been introduced in the House of Representatives by Russo (D-IL), Sanders (I-VT), and Stark (D-CA), ("Best National Health Care Bill", 1991; Geisel, 1991a). Another plan placed the school at the center of it's NHI plan (Freedman, Klepper,

Duncan & Bell, 1988), called "School Enrollment-Based Family Health Insurance" (p. 843).

In a report released by the U. S. Congress General Accounting Office, it was concluded that the "U. S. would provide better health care and save money by adopting a plan similar to that of Canada" (Rabban, 1991, p. 1).

3. National Health Service

A national health service (NHS) "seeks to provide direct services to all citizens, rather than merely financing a private medical sector to augment the public sector" (Brown, 1985, p. 215). Brown believes that an NHS is the best solution to the healthcare crisis; although, it will be "difficult to obtain" (p. 215). This type of system is also supported by Bayer et. al, (1988). Among other benefits of an NHS would be that it "would enhance social solidarity and provide a focus for national sharing and mutual concern" (Dougherty, 1988, p. 177).

The National Health Services Act was introduced by Rep. Ron Dellums in 1976 and has been reintroduced each year since as a plan for a U. S. NHS modeled after Britain's system (Harrington, 1988).

4. Managed Competition

The concept of "managed competition" is attributed to the "Jackson Hole Group" (Rubin, 1993). The group is "lead by Dr. Paul Ellwood of Minnesota and Prof. Alain Enthoven of Stanford University... and includes academics, health care executives and physicians" (Fisher, 1992, p. 24). Enthoven and Kronick (1989) define

managed care as a "market structure...in which intelligent collective agents, called sponsors, contract with competing health plans and continuously monitor and adjust the market to overcome its tendencies to failure". McGroth (1993) explains managed competition as being "based on two fundamental beliefs": one, that "competition serves consumers better than bureaucrats or self-interested third parties" and two, that "effective and just healthcare competition requires careful fine-tuning" (p. C-1, 19). McGroth does not spell out who the ones doing the fine-tuning are though. Managed competition, according to Rubin (1993), "suggests that three or more health plans be offered in a particular geographic area" (p. 16). Vanden Bos (1993) explains that "most managed competition plans include a standard minimum benefit package" that includes universal access and "price competition among plans through purchasing cooperative groups" (p. 284).

Many people are confused as to what exactly is "managed competition," while Vanden Bos indicates that "no one seems to agree" what it is (1993, p. 284). Morris (1993) puts the confusion succinctly when he reports "few of us can understand what managed competition is and how it will reduce health costs" (p. 7A). Fifer sees managed care "may be the last hope to bring health care costs under control and avert the establishment of a national health insurance system" (quoted in Geisel, 1991b, p. 28).

Critics of this concept are many. Glaser (1993) argues that competition "presses insurance to companies to reduce benefits and coverage, not to improve them" (p. 811). While Relman, a respected physician, stresses that competition in medicine "has no

relationship to reality" (cited in Hackman & Howard, 1989, p.32) and that "health care is not an economic commodity" and "cannot be bought and sold" (p.34). Concurring with this view is Kosteer-Dreese (the president of a Dutch patient's consumer group) who attests that "the suggestion that public health is a free market is ridiculous" (cited in Meyer, 1989a, p. 9). Kosteer-Dreese goes on to state "people in bad health don't freely chose to have care" (p. 9). Carrier and Kendall (1990) argue that "those in greatest need are rarely those with the ability to pay to satisfy their need" (p. 8). The Oil, Chemical and Atomic Workers (1992) contends that managed competition is "a disastrous proposal that relies on the current system of employer -provided health coverage and the private insurance industry" (p. 1).

5. Extensions of Current Mechanisms

Former Surgeon General Koop has spoken out in the past against what he called "nationalized medicine" (1991, p. 3C) and in favor of a mixture of private insurance and public plans that would provide coverage for all of the poor. This approach is also supported by Bronow et. al. (1991).

Rep. Stark introduced "MediPlan" that would offer universal coverage using the Medicare reimbursement system (Fisher, 1990b). An incremental plan to expand Medicare has also been proposed by Intriligator (1993). The U. S. Health Program Act, introduced by Rep. Roybal, would utilize private insurers like Blue Cross/ Blue Shield to administer a governmental program (Harrington, 1988; Roybal, 1991). Sen. Kennedy has introduced his "Health America" plan that

would build on the current system and provide coverage for all (Kennedy, 1991).

5. Minor Changes in Status Quo

Several plans have been put forth that would make minor changes in the current system and not enact any substantive or systematic change ("AMA Proposes," 1989; Howard, 1990; Sharfstein, Stoline & Goldman, 1993).

One critic, however, points out "the current policy debate regarding how best to *reform U. S. health care* fails to adequately address the question of how to *improve the nation's health* " (italics in original) (Aday, 1993, p. 738).

Current Proposals

There has been a wide variety of reform plans, in addition to the ones listed above, that have been put forth in the past few years (e.g. Council on Medical Care, 1989; Daschle, Cohen & Rice; Davis, 1989b; Dentzer, 1994; Enthoven & Kronick, 1989; Fisher, 1990; Hiatt, 1987/1989; Insurance Reform Outlined, 1990; Kern & Bresch, 1990; Kerrey & Hofschire, 1993; Klette, 1987: Oil, Chemical & Atomic Workers, 1989; Pearson, 1990; Sharfstlin, Stoline & Goldman, 1993; Wagner, 1994).

We will cover the major plans, as of this writing (June, 1994). These are: 1) Health Security Act of 1993 (the Clinton plan), 2) American Health Security Act of 1993 (McDermott/Wallstone), 3) Affordable Health Care Act of 1993 (Michel/Lott), 4) Managed Competition Act of 1993 (Cooper/Breaux), 5) Health Equity and

Access Act of 1993 (Chaffee/Thomas), 6) Consumer Choice Health Security Act of 1993 (Stearns/Nickles), and 7) Comprehensive Family Health Access and Savings Act. Now let us examine each in detail.

1. Health Security Act

This act is commonly known as the Clinton Plan after the President. It was developed by H. R. Clinton, chair of a special task force appointed by President Clinton, and the Clinton administration ("Health Security Preliminary Plan Summary" (1993). The main sponsors of the bill are Rep. Gephart (D-MO) and Sen. Mitchell (D-ME) (Dentzer (1994). It has 100 House co-sponsors and 31 Senate co-sponsors. The book containing the printed Act weighs in at 2 lbs., 9 ozs. and is 1368 pages long. ("Proposed Legislation", 1993).

The bill has six underlying principles according to "Health Security, the President's Report to the American People (1993): "security " - "guaranteeing comprehensive benefits to all Americans" (p.17); "simplicity" - "simplifying the system and cutting red tape" (p. 18); "savings" - "controlling health care costs" (p. 18); "quality" - "making the world's best care better" (p.19); "choice, " - "preserving and increasing the options you have today" (p. 20) (to chose physicians and hospitals); and, "responsibility" - " making everyone responsible for health care." (p.20). It would require "mandatory coverage for all citizens and legal residents" (Wagner, 1994, p. 24)

Highlights of the plan include having states form "health alliances" which "means a non-profit organization, an independent state agency, or an agency of the state" (p. 119) and includes a board

of directors, which would chose two or three plans that residents in the areas could chose from each year ("Health Security, the President's Report to the American People, 1993). States can elect to enact single-payer systems instead of the alliances ("Health Security, the President's Report to the American People, 1993). The act liberally covers mental illness and substance abuse treatment, outpatient and inpatient medical care, prescription drugs; supports medical research and training, prevention, regular surveys of consumer satisfaction; and raises taxes on tobacco products ("Health Security, the President's Report to the American People, 1993). It also prohibits companies from dropping individuals for any reason.

Employers will be required to pay 80% of premiums, unemployed people will purchase their coverage through the regional alliances, "with subsidies for low-income persons" (Wagner, 1994, p.24). A key part of Clinton's plan is managed competition (Koyanagi et al., 1993; Neumann, 1993). A group of mental health workers and consumers have urged Clinton to not use managed care because of its "focus on cost rather than care; bias toward crisis intervention rather than psychotherapy; limited provider choice; invasion of privacy; and a fear on the part of providers and clients to complain to managed care companies" ("Providers to Clinton", 1993, p. 3).

Counselors are not specifically included in the Clinton plan, as are psychologists, but it refers to state-approved providers, which could allow many counselors to be providers.

2. American Health Security Act

This act is commonly known as the McDermott/Wellstone bill, after the main sponsors, Rep. McDermott (D-WA) and Sen. Wellstone (D-MN). It has 92 House co-sponsors and 5 Senate co-sponsors. (Wagner, 1994).

This bill is a single-payer plan (Dentzer, 1994; "Health care security for all", 1993; "Wellstone bill provides", 1993; Wellstone & Shaffer, 1993). It would require "mandatory coverage for all citizens and legal residents" (Wagner, 1994, p. 24). Wellstone and Shaffer (1993) state that the elements of the bill include:

> fixed annual budgets; free choice of providers...streamlined and publically accountable administration; universal coverage based on residency...comprehensive benefits with an emphasis on primary and preventative care; quality controls based on outcomes data...equitable financing; and affordability (p. 1489).

Private insurance would be eliminated (Wagner, 1994). Mental health and substance abuse care would be "affordable, along with services to coordinate care" (Wellstone & S
haffer, 1993, p. 1491). Sen., Wellstone has stated "report after report shows conclusively that single payer is the best policy" (cited in "Congressional Budget Office Shows", 1993, p. 1).

3. Affordable Health Care Now Act

This act is commonly known as the Michael/Lott bill, after the main sponsors, Rep. Micheal (R-IL) and Sen. Lott (R-MS). It has 139 House co-sponsors and 10 Senate co-sponsors. (Wagner, 1994).

This act contains no mandate for universal coverage; but employers must offer coverage, but are not required to pay for it (Wagner, 1994). National Health Law Program (1994a & 1994d) contends that the bill provides no new funding for healthcare and would leave 36 million people uninsured.

Dentzer (1994) characterizes this bill as a "low-budget House GOP plan [that] focuses on insurance reforms but minimal structural change" (p. 37).

4. Managed Competition Act

This act is commonly known as the Cooper/Breaux bill, after the main sponsors, Rep. Cooper (D-TN) and Sen. Breaux (D-LA). It has 57 House co-sponsors and 4 Senate co-sponsors. (Wagner, 1994).

This act contains no mandate for universal coverage; but employers must offer coverage, but are not required to pay for it (Wagner, 1994). Access to insurance is "expanded through insurance reforms that guarantee renewal and portability" and "government subsidies for low-income" people to purchase insurance, and "through formation of purchasing pools for small business and individuals" (Wagner, 1994, p. 24). National Health Law Program (1994a) reports that this bill "abolishes Medicaid and provides some coverage to people with incomes below the poverty line ($14,350 a year for a family of four)" (p. 1). Additionally, they indicate that the bill would "leave 25 million uninsured" (1994b, p. 1).

Denzer (1994) puts forth that this bill's "plan to unleash market forces to contain costs draws support from moderates, insurers and drug companies" (p. 34).

5. Health Equity and Access Reform Today Act

This act is commonly known as the Chafee/Thomas bill, after the main sponsors, Rep. Chafee (R-RI) and Sen. Thomas (R-CA). It has 4 House co-sponsors and 20 Senate co-sponsors. (Wagner, 1994).

This act would require coverage of all citizens ("but only if savings show up", reports Dentzer, 1994, p. 34), employers must offer coverage but are not required to pay for it, and "individuals are required to buy insurance, with federal subsidies for low-income individuals" (Wagner, 1994, p. 24).

6. Consumer Choice Health Security Act

This act is commonly known as the Sterns/Nickles bill, after the main sponsors, Rep. Sterns (R-FL) and Sen. Nickles (R-OK). It has 18 House co-sponsors and 25 Senate co-sponsors. (Wagner, 1994).

This bill includes no mandatory coverage, but would require individuals to "purchase a catastrophic health insurance plan by 1997 or forfeit their personal income tax exemption (Wagner, 1994, p.24). Although, supporters of the bill contend that it does provide universal coverage (Dentzer, 1994).

7. Comprehensive Family Health Access and Savings Act

This act is commonly known as the Gramn bill, after the main sponsor, Sen. Gramn (R-TX). It has 10 Senate co-sponsors and has not been introduced in the House. (Wagner, 1994).

This bill includes no mandatory coverage, but would require individuals to "purchase a catastrophic health insurance plan"; with

"those who don't would have wages garnisheed for seven years for unpaid medical bills" (Wagner, 1994, p. 24).

Opponents

Several persons and organizations have announced their opposition to national healthcare and/or specific kinds of plans. Opponents to national health insurance are: insurance companies (Vall-Spinosa, 1990); insurance company executives (Fisher, 1989a); Malcom Forbes, Jr. (Forbes, 1992); former Health and Human Services Secretary Sullivan (Sullivan, 1992); former U.S. Surgeon General C. Everat Koop ("Koop blasts", 1991); Fortune 1,000 corporate executives (Brostoff, 1990; Thompson, 1990a); Health Insurance Association of American (Thompson, 1990b); U. S. companies (Schwartz, 1990a; Vall-Spinosa, 1990); and others (Goodman, 1990b; Vall-Spinosa, 1990). Those opposed to a Canadian-style system include: Bronow (1990); Goldsmith (1989); hospital CEOs (Johnsson, 1990); physicians (McDougall, 1990; Sislen, 1990; Todd, 1989); U. S. health insurance companies (Vall-Spinosa, 1990; Woolsey, 1990); and others (Kosterlitz, 1989b; Vall-Spinosa, 1990; Walker, 1990).

One group, the Coalition for Health Insurance Choices (CHIC) presents itself as a group out to protect the consumer from runaway government meddling and runs TV commercials urging people to call congress to oppose healthcare reform (Pieragostini, 1994). The organization was actually created by the Health Insurance Association of America which has approximately 270 insurance companies as members (Pieragostini, 1994). CHIC wants to block

reforms that would hinder the insurance companies profit-making abilities (Pieragostini, 1994).

Proponents

Many people and organizations have endorsed some form on national healthcare. Business persons and groups include: American Airlines head, Robert Crandall (Oil, Chemical & Atomic Workers, 1989); business leaders (Untitled, 1993; Waldman, 1989); former Chrysler Company head Lee Iacocca (Adelman, 1989; Iacocca, 1989); and hospital CEOs (Johnsson, 1990)

Labor and community groups support includes: AFL-CIO (Baker, 1991; Boatman, 1991; Fisher, 1989b; Grayson, 1993;); grassroots union support (Woodward, 1991); Gray Panthers ("Gray Panthers Principles", 1990; Mixson, 1991); Northeast Ohio Coalition for National Health Care ("Editorial Comment, 1989); several national and international American unions (Cowell, 1991); John Sweeney {President of the Service Employee International Union, the largest healthcare worker union in the U. S.} (Burke, 1990); the Teamsters Union, the largest union in the U. S. (Grayson, 1993); with the United Auto Workers supporting a Canadian-style single-payer system ("Health Insurance Blowout", 1990).

Medical organizations, physicians and/or publications include: American Academy of Family Physicians (Montauck, 1991); American Academy of Pediatrics (Somerville, 1989b); American College of Physicians, the first medical group to support national healthcare (Greer, 1990); American Nurses Association (1991)[and forty-two additional nursing organizations]; Toufexis, (1990); Enthoven (1989);

The New England Journal of Medicine ("Editorial Comment, 1989); and Physicians for a National Health Program ("OCAW Produces", 1990).

Additionally, consumers of healthcare, the citizenry of the U. S. have shown in many polls that they support healthcare reform (Blendon & Donelan, 1990; Colastosi, 1990; Ginzberg, 1990; McIlrath, 1990; Santiago, 1992; "This Year's College Freshman", 1991; Thompson, 1990b). In a recent non-random survey of 10,675 North Dakota voters completed by U.S. Rep. Pomeroy, it was found that 56% of respondents to the question, "Are you satisfied with the health insurance system in the United States generally?" responded "Somewhat" or "Very Dissatisfied" (Pomeroy, 1994, p.1). These results coming from a state that is not generally know for it's current progressive political thinking.

Last, but certainly not least, the American Counseling Association (formerly American Association for Counseling and Development) has been active in advocating and lobbying for reforms (American Association for Counseling and Development, 1991a, 1991b, 1991c; American Counseling Association, 1992, 1993a, 1993b; American Counseling Association Public Policy and Legislation Committee, 1992; Koyangi, Manes, Surles & Goldman, 1993). Several other professional organizations that represent mental health workers from many disciplines support healthcare reform, including American Nurses Association, American Psychiatric Association, American Psychological Association, and American Association of Marriage and Family Therapists (and others) (Koyangi, Manes, Surles & Goldman, 1993).

Where Do We Go From Here?

Many proposals are likely to be introduced in the U. S. Congress, as well as in state legislative bodies before all is said and done. "Nobody," states Dentzer (1994) "expects any of the six major competing reform plans, including Clinton's, to survive...intact" (p. 30). It is unlikely that a radical change will be enacted, as Aaron (1992) points out, this "would require a massive redistribution of income among classes, industries, and regions" (p. 24). What is likely is that some form of national system will emerge. The President's plan would greatly improve the quality of healthcare for most citizens. It is not the ideal plan. It will require modifications in the near future. But, it is better than what we have; and, therefore, it deserves the critical support of counselors. We are obligated to work towards establishing a more humane society and this will be a step in that direction.

One element to keep in mind when discussing healthcare reforms is that, as Evans (1989) eloquently states,

> people do not choose to be ill and do not want to use health care. The fact of needing health care services marks off individuals as less - not more - fortunate than the rest of the community, and, therefore, provides no grounds for exposing them to additional economic burdens as well (p. 82).

Also, as Levin (1991) brings to light, no medical procedure "can make up for the cumulative effects of poor nutrition and housing" (p.42). "Our environment-psychological, social and physical- " Levin concludes, "is the main source of ill health in the U. S." and if we do not attend to these issues "medical costs for dealing with the

symptoms will continue to escalate" (p.42). McBeath (1991) professes that "to a large extent, health depends on the political, social, cultural, economic, and physical environments in which we live" (p. 1563). Former Surgeon General Koop places "poverty...at the base of almost all the problems that I see in health" (cited in Neff, 1990, p. 31)

Why National Healthcare Should Be Supported

Some rational system of national healthcare is needed. We can no longer sit idly by and watch our fellow citizens suffer because they do not have the resources to obtain needed medical attention. Navarro (1987) argues for supporting national healthcare because "(1) it is the moral and principled thing to do...(2) it makes sense; and (3) people want it. As simple as that" (p. 154).

Sidel (1987) contends that "in our wealthy society we could equitably provide both advanced medical treatment and more preventive and basic health care if we chose to" (p. 24). Trimbrell (1992) calls national healthcare "an investment in the human resources of a nation" (p. 370). Joelson (1990) states that "paying in advance for universal health care is the most efficient method for delivering medical services" (p. 35); and Francis (1988) asserts that "if expenses are spread out across the entire society" for medical care then "unit costs drop dramatically and society can provide efficient and relatively cheap care for all" (p. 9).

Sidel and Sidel (1984a), long-time reform advocates and supporters of a Swedish-style system, state some reformers have

maintained that "nothing short of fundamental restructuring of the medical care system...could produce the needed change" (p. 2).

It is time to set aside our social conditioning and embrace sweeping changes in our system. We need to stive for a rational, universal system that places the health of people above the profit-motive. A Swedish-style system would be most preferable, but politically unattainable at this point in time in the U. S. As a compromise, a single-payer system would be the most humane. And, if nothing better can be got, Clinton's plan would be a step in the right direction.

Counselors Must Be Involved

We must take action to impact the outcome of the national healthcare debate. As Haight(1982) argued "particular laws do have a major impact on the counseling profession" (p. 605). Lewis and Moore declare that counselors "are becoming increasingly aware of the importance of political action" (1982, p. 622). But we must act not just out of our own professional self-interest, but also out of our professional and personal concerns and commitment to "enhancing the individual (and the society)" and commitment to social and economic justice. We must become better organized in impacting social and public policy, lobbying for progressive healthcare reforms and working in coalition with other mental health providers, professional organizations, labor unions and consumer groups, such as the effort described in Koyangi, Manes, Surles and Goldman (1993). We "must become more politically astute" as Pinson-Millburn advocates (1982, p. 581).

This is the time to set aside petty "turf" concerns. We should work to have all competent, professional providers included as a part of the new system to deliver quality services to the people of the United States. But, if counselors are not included, or worse yet, excluded, dark days are ahead for counselors who work outside of school settings.

As we strive for these reforms in the healthcare system "we must also strive for basic change in our society, for the movement of our nation and of others toward a world in which we can be just, secure, peaceful, communal and healthy" (Sidel & Sidel ,1984b, p. 284). Idealism must not die within us, or else we will lose our humanness.

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